

## CERTIFICATE OF DEATH

Reg. Dist. No.

04661

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>aa</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md 0210.2</u>			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>Schoeffers Nursing Home</u>				d. STREET ADDRESS <u>225 Severn Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>BOSMAN</u> Last <u>BENNETT</u>				4. DATE OF DEATH Month <u>4-</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-27-1893</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Civil Service</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clerk U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>William F. Bennett</u>			
14. MOTHER'S MAIDEN NAME <u>Edith Bosman</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service) <u>-</u>			
16. SOCIAL SECURITY NO. <u>-</u>				17. INFORMANT <u>Charles Bennett</u> Address <u>(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u>						INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 31, 1958</u> to <u>April 2, 1958</u> , that I last saw the deceased alive on <u>March 31, 1958</u> , and that death occurred at <u>5:30 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas F. Herbert</u> M.D.				ADDRESS (Street, city or town, state) <u>46 Church Rd</u>			
PHYSICIAN'S NAME (Type) <u>Thomas F. Herbert M.D.</u>				DATE SIGNED <u>4/2/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-5-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>				ADDRESS <u>Annapolis Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 7 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Alfred</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint, illegible text]		SEX [Faint, illegible text]		AGE [Faint, illegible text]	
PLACE OF BIRTH [Faint, illegible text]		DATE OF BIRTH [Faint, illegible text]		PLACE OF DEATH [Faint, illegible text]	
OCCUPATION [Faint, illegible text]		CAUSE OF DEATH [Faint, illegible text]		MANNER OF DEATH [Faint, illegible text]	
SIGNATURE OF PHYSICIAN [Faint, illegible text]		SIGNATURE OF CORONER [Faint, illegible text]		SIGNATURE OF REGISTRAR [Faint, illegible text]	
DATE [Faint, illegible text]		TIME [Faint, illegible text]		PLACE [Faint, illegible text]	

BUREAU V. S.

APR 7 1958

RECEIVED

## 4670 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> c. LENGTH OF STAY IN 1b <b>Ellicott City</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Old Frederick Road</b>				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> d. STREET ADDRESS <b>Old Frederick Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CHARLES W. FUNK</b> First Middle Last				4. DATE OF DEATH <b>April 24, 1958</b> Month Day Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 8, 1898</b>	
9. AGE (In years lost birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Doughnut Corp.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Mfg.</b>		11. BIRTHPLACE (State or foreign country) <b>Toms Brook Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Israel Funk</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Whitmire</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>216-07-4019</b>		17. INFORMANT <b>Mrs. Gertrude E. Funk, Ellicott City, Md.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> <b>237X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>BRAIN TUMOR</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 YRS -</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>ELICOTT CITY, MD</b>				20g. (County) <b>HOWARD</b>		20h. (State) <b>MARYLAND</b>	
21. I certify that I attended the deceased from <b>JAN 5, 1958</b> , to <b>APRIL 24, 1958</b> that I last saw the deceased alive on <b>APRIL 24, 1958</b> , and that death occurred at <b>6:50 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>COLUMBIA RD ELICOTT CITY, MD</b> DATE SIGNED <b>4-25-58</b> ACTUAL SIGNATURE <b>Peter V. Thorpe</b> M.D. PHYSICIAN'S NAME (Type) <b>PETER V. THORPE, MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-27-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd</b>		22d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md.</b> ADDRESS				24a. REC'D BY REGISTRAR DATE <b>APR 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		MALE		45		JAN 15 1888		BALTIMORE, MARYLAND	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
LABORER		HEART DISEASE		NATURAL		APR 15 1953		BALTIMORE, MARYLAND	
FATHER'S NAME		MOTHER'S NAME		DATE OF MARRIAGE		DATE OF INTERMENT		PLACE OF INTERMENT	
JAMES H. HARRIS		MARY J. HARRIS		JAN 15 1910		APR 15 1953		BALTIMORE, MARYLAND	
<p>DECLARATION OF DEATH: I hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased.</p> <p>Signed: JAMES H. HARRIS, M.D., M.D.</p> <p>Signed: JAMES H. HARRIS, M.D., M.D.</p>									

BUREAU Y. S.

APR 28 1953

RECEIVED

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04663

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Daisy</b>		c. LENGTH OF STAY IN 1b <b>10 Years</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Daisy</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Daisy Road</b>				d. STREET ADDRESS <b>Daisy Road Woodbine</b>	
3. NAME OF DECEASED (Type or print) <b>LEILA STULL HAIGHT</b>		4. DATE OF DEATH Month <b>4</b> Day <b>19</b> Year <b>58</b>		5. SEX <b>Female</b>	
6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 22 1891</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13. FATHER'S NAME <b>Ulysses G. Stull</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Keyser</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Charles F. Haight, woodbine, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Strangulation by hanging</b> 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Self strangulation using electric cord tied to rafter in attic</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 Min.</b>	
20c. TIME OF INJURY Month, Day, Year <b>1.15 P.M. 4-19-58 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>At home</b>	
20f. (City or town) <b>Daisy</b>		20g. (County) <b>Howard</b>		20h. (State) <b>Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>George E. Burgtorf</b>		EXAMINER'S NAME (Type) <b>George E. Burgtorf</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>4-19-58</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 22</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove</b>	
22d. LOCATION (City, town, or county) <b>Glenwood</b>		22e. (State) <b>Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ray W. Barber</b>		ADDRESS <b>Laytonsville, Md</b>		24a. REC'D BY REGISTRAR DATE <b>Apr 22 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Ray W. Barber</b>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND  
DEPARTMENT OF HEALTH

DATE OF DEATH  
PLACE OF DEATH

IN DEATH

WOODHINE

DEPT, SS 1891 88

U.S.A.

MARY JANE KEYSER

WOODHINE, MD.

None

CHARLES E. HAYES

BUREAU V. 8

APR 22 1953

RECEIVED

STATIONVILLE, MD  
OAK GROVE  
APRIL 22 1953

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

Item 7, Film G228 4/28/58 fcy

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Bethesda</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dayton</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Tridelphia Road</b>		d. STREET ADDRESS <b>2724 Yarnall Road</b>	
3. NAME OF DECEASED (Type or print) First <b>JACOB</b> Middle <b>CHARLES</b> Last <b>HOWE</b>		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 20, 1934</b>
9. AGE (in years last birthday) <b>23 yrs.</b>		IF UNDER 1 YEAR Months <b>23</b> Days <b>17</b> Hours <b>15</b> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bond Bakery</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Jacob Howe Sr.</b>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>yes 1953-56</b>		16. SOCIAL SECURITY NO. <b>220-36-7619</b>	
17. INFORMANT <b>Benny West</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple traumatic injuries</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Truck ran off road</b>	
20c. TIME OF INJURY Month, Day, Year <b>12 noon 4/17 1958</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Road</b>		20f. (City or town) (County) (State) <b>Howard Md.</b>	
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>R. S. Fisher</b>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/21/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Moreland</b>		22d. LOCATION (City, town, or county) (State) <b>Bethesda Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Moreland &amp; Son 28</b>		24a. REC'D BY REGISTRAR <b>APR 22 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 22 1958

BUREAU V. S.

STATE  
HEALTH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4673

## CERTIFICATE OF DEATH

Reg. Dist. No.

04665

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marriottsville</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Marriottsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>BERTHA</u> Middle <u>KING</u> Last <u>KING</u>				4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-8-1885</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Cooksville, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Smith</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Dennis King, Marriottsville, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC failure, Arteriosclerotic</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HEART DISEASE, Hypertension,</u> DUE TO (c) <u>CEREBRAL HEMORRHAGE, Rt Hemiplegia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1956 to April 1958</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month. Day. Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>89 AM</u> 19 <u>10 April</u> 1958, that I last saw the deceased alive on <u>10 April</u> 1958, and that death occurred at <u>12 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard E. Hall</u>				ADDRESS (Street, city or town, state) <u>Agnew, Md</u>		DATE SIGNED <u>10 April 58</u>	
PHYSICIAN'S NAME (Type) <u>Howard E. Hall</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-13-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>West Liberty</u>		22d. LOCATION (City, town, or county) <u>Alpha, Md</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham, Elli ott City, Md</u>				24a. REC'D BY REGISTRAR DATE <u>APR 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	

CERTIFICATE OF DEATH

DECEASED: **BERTHA**  
 SEX: **F**  
 AGE: **78**  
 DATE OF BIRTH: **1880**  
 PLACE OF BIRTH: **King**  
 OCCUPATION: **None**  
 MARITAL STATUS: **Widow**  
 DECEASED AT: **Home**  
 DATE OF DEATH: **April 14, 1938**  
 TIME OF DEATH: **10:30 AM**  
 CAUSE OF DEATH: **Cardiac Failure, Atherosclerosis**  
 DISEASE OR INJURY: **Heart Disease, Hypertension**  
 PRESENT ILLNESS: **Cerebral Hemorrhage & Hemiparesis**

BUREAU V. E.

APR 14 1938

RECEIVED

APR 14 1938

APR 14 1938

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4674 CERTIFICATE OF DEATH

04666

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. LENGTH OF STAY IN 1b <u>Ellicott City</u> X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kerger Rd.</u>		d. STREET ADDRESS <u>Kerger</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Nannie</u> First <u>A.</u> Middle <u>KUHN</u> Last		4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/10/1886</u>
9. AGE (In years lost birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>  </u>	
13. FATHER'S NAME <u>William C. Mouring</u>		14. MOTHER'S MAIDEN NAME <u>Susan Thorton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Joseph E. Kuhr</u>		Address <u>Kerger Rd., Ellicott City, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRO-VASCULAR ACCIDENT</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>20 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>			
21. I certify that I attended the deceased from <u>19 57</u> to <u>April 16</u> , <u>19 58</u> , that I last saw the deceased alive on <u>April 16</u> , <u>19 58</u> , and that death occurred at <u>1:00 A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Columbia Road Ellicott City, Md.</u> DATE SIGNED <u>4-17-58</u>			
ACTUAL SIGNATURE <u>P. V. Thorpe</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Peter V. Thorpe, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/19/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>	22d. LOCATION (City, town, or county) (State) <u>Ellicott City Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham</u> ADDRESS <u>Ellicott City, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 21 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>  </u>	

CERTIFICATE OF DEATH

See Page 100

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
JAMES EARL RAY		Male		35		White		April 14, 1928		Memphis, Tennessee	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. PLACE OF DEATH		11. DATE OF DEATH		12. TIME OF DEATH	
Attorney		Suicide		Suicide		Home		April 4, 1968		10:00 AM	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESS		16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF CLERK	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
19. MEDICAL HISTORY		20. SOCIAL HISTORY		21. PSYCHOLOGICAL HISTORY		22. PATHOLOGICAL HISTORY		23. LABORATORY TESTS		24. OTHER TESTS	
[Text]		[Text]		[Text]		[Text]		[Text]		[Text]	

BUREAU V. 2

APR 21 1968

RECEIVED

4675

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mayfield</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Ellicott City</b> d. STREET ADDRESS <b>Mayfield</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM T. LETBOLT</b>				4. DATE OF DEATH Month Day Year <b>April 15 19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-25-1871</b>	9. AGE (In years last birthday) yrs. <b>86</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>NW 1</b>		17. INFORMANT <b>Mrs. Margaret Carroll, Ellicott City, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CEREBRAL THROMBOSES</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>36 HRS.</b> <b>1 wk.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town): (County) (State)	
21. I certify that I attended the deceased from <b>4-12</b> , 19 <b>58</b> , to <b>4-15</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>4-15</b> , 19 <b>58</b> , and that death occurred at <b>6:45 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Donald E. Fisher</b> M.D. <b>ELLICOTT CITY</b> <b>4-17-58</b> PHYSICIAN'S NAME (Type) <b>DONALD E. FISHER MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-19-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd</b>		22d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>				24a. REC'D BY REGISTRAR DATE <b>APR 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 21 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04668

4676

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Guilford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Guilford</u>	
c. LENGTH OF STAY IN 1b <u>85 yrs</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GEORGE</u> First <u>MOORE</u> Last		4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1873</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Howard &amp; Md</u>	
11. BIRTHPLACE (State or foreign country) <u>Howard &amp; Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>  </u>	
13. FATHER'S NAME <u>George Moore Jr</u>		14. MOTHER'S MAIDEN NAME <u>Cassie Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Henry Moore</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocarditis</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 16</u> , 19 <u>58</u> , to <u>April 20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 19</u> , 19 <u>58</u> , and that death occurred at <u>11 A</u> . M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert S. McCeney</u>		ADDRESS (Street, city or town, state) <u>402 Main Street</u>	
PHYSICIAN'S NAME (Type) <u>Robert S. McCeney, M. D.</u>		DATE SIGNED <u>7/22/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 23/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ashbury Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Junction Road</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ridgley Selby</u>		24a. REC'D BY REGISTRAR DATE <u>APR 24 '58</u>	
ADDRESS <u>401 Washington</u>		24b. REGISTRAR'S SIGNATURE <u>W. S. Seach</u>	

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## CERTIFICATE OF DEATH

Reg. Dist. No.

04669

1. PLACE OF DEATH o. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>	c. LENGTH OF STAY IN 1b <u>33 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3512 Main St</u>		d. STREET ADDRESS <u>15512 Main St</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>WEEMS WILLIAM SOTHORON</u> First Middle Last		4. DATE OF DEATH <u>April</u> Month Day Year <u>3</u> <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 5 1880</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Belt maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Elkridge MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Sothoron</u>		14. MOTHER'S MAIDEN NAME <u>Jennie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>100-100-10000</u>	
17. INFORMANT <u>Mrs Ruth Ryan</u>		Address <u>5503 Main St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 350x DUE TO <u>Coronary Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO <u>Hypertrophic Arteriosclerosis</u> (c) <u>Obesity</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 mo 10 yrs 5 yrs 5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Decubitus ulcers</u> 2 mo			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan</u> , 1957, to <u>Apr 3</u> , 1958, that I last saw the deceased alive on <u>Apr 3</u> , 1958, and that death occurred at <u>6:05</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B B Brumbaugh</u> M.D.		ADDRESS (Street, city or town, state) <u>9609 Main St</u> DATE SIGNED <u>4/5/58</u>	
PHYSICIAN'S NAME (Type) <u>B B Brumbaugh</u>		<u>Elkridge MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr 7 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Grace</u>	22d. LOCATION (City, town, or county) (State) <u>Elkridge MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herry W Jenkins</u>		ADDRESS <u>South 495 York Rd</u>	
24a. REC'D BY REGISTRAR <u>APR 7 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Deborah</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## 4678 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>				c. LENGTH OF STAY IN 1b <b>Ellicott City</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Folly Quarter Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LIZZIE</b> Middle <b>SUPER</b> Last				4. DATE OF DEATH Month <b>April</b> Day <b>28</b> Year <b>19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-4-1869</b>	
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Henry Super</b>				14. MOTHER'S MAIDEN NAME <b>Anne Ashenburner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Henry Karsten, Ellicott City, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac failure</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>10 years</b>				INTERVAL BETWEEN ONSET AND DEATH <b>27 hrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 24, 1957</b> , to <b>April 20, 1958</b> , that I last saw the deceased alive on <b>April 27, 1958</b> , and that death occurred at <b>734 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles S. Whitaker</b> M.D. <b>CLARKSVILLE, MD</b>				DATE SIGNED <b>4/29/58</b>			
PHYSICIAN'S NAME (Type) <b>CHARLES S. WHITAKER, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-1-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Christ Church</b>		22d. LOCATION (City, town, or county) (State) <b>Quilford, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. C. Higinbotham, Ellicott City, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 30 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 30 1953

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